

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 0 — 0 0 8

2. STATE:

HAWAII

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)
MEDICAL ASSISTANCETO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

JANUARY 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 C.F.R. SECTION 447.253

7. FEDERAL BUDGET IMPACT:

a. FFY 2000 \$ 220,554

b. FFY 2001 \$ 441,108

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

ATTACHMENT 4.19-A
PAGES 1, 3, & 109. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):ATTACHMENT 4.19- A
PAGES 1, 3, & 10

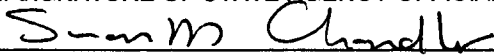
10. SUBJECT OF AMENDMENT:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES PROSPECTIVE REIMBURSEMENT SYSTEM
FOR INPATIENT SERVICES

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED: APPROVED BY GOVERNOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

SUSAN M. CHANDLER, M.S.W., Ph. D.

14. TITLE:

DIRECTOR

15. DATE SUBMITTED:

DECEMBER 1, 2000

16. RETURN TO:

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION
P.O. BOX 339
HONOLULU, HAWAII 96809-0339

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

December 11, 2000

18. DATE APPROVED:

March 8, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Linda Minamoto

22. TITLE:

Associate Regional Administrator

23. REMARKS:

STATE OF HAWAII

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
PROSPECTIVE REIMBURSEMENT SYSTEM FOR INPATIENT SERVICES**

I. GENERAL PROVISIONS

A. PURPOSE

This plan establishes a reimbursement system for acute care facilities which complies with the Code of Federal Regulations. It describes principles to be followed by Title XIX acute care providers in making financial reports and presents the necessary procedures for setting rates, making adjustments, and auditing the cost reports.

B. OBJECTIVE

The objective of this plan is to establish a prospective payment system that complies with the Balanced Budget Act of 1997, which requires that reimbursements be in conformity with applicable State and Federal laws, regulations; quality and safety standards; and provide for cost reimbursement for inpatient acute care services in Critical Access Hospitals (CAH).

C. REIMBURSEMENT PRINCIPLES

1. The Hawaii Medicaid Program shall reimburse Providers for inpatient institutional services based primarily on the prospective payment rates developed for each facility as determined in accordance with this Plan, except for CAH. In addition, certain costs (such as Capital Related Costs) shall be reimbursed separately. The estimated average proposed payment rate under this plan is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the Department reasonably estimates would be paid for those services under Medicare principles of reimbursement.

TN No. 00-008

Supersedes

TN No. 00-001

Approval Date MAR 8 2001 Effective Date 1/01/01

7. Claims for payment shall be submitted following discharge of a patient, except as follows:
 - a. Claims for nonpsychiatric inpatient stays which exceed the Outlier Threshold (Section I.D.34.), shall be submitted in accordance with Section IV.D.
 - b. If a patient is hospitalized in the freestanding rehabilitation hospital for more than 30 days, the facility may submit an interim claim for payment every 30 days until discharge. The final claim for payment shall cover services rendered on all those days not previously included in an interim claim.
8. The prospective payment rates shall be paid in full for each Medicaid discharge. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except for outlier payments and as provided in Section I.E. below.
9. At the point that a patient reaches the Outlier Threshold (Section I.D.34.), the facility is eligible for interim payments computed pursuant to Section IV.D.
10. Reimbursement for inpatient services provided by CAH facilities will be on a reasonable cost basis under Medicare principles of reimbursement (subject to the lower of cost or charges rule) without application of any Medicaid TEFRA target amounts. Outpatient, waitlisted and acute swing to continue to be reimbursed under the current method.

TN No. 00-008
Supersedes
TN No. 94-006

Approval Date MAR 8 2001 **Effective Date** 1/01/01

(Basic Per Discharge Rate)
(ROE/GET Adjustment [if applicable])
(Medical Education Adjustment Factor [if applicable])
(cumulative Inflation Factor)

38. "Waitlisted patient" means a patient who no longer requires acute care and is awaiting placement to a long-term care facility.
39. "Critical Access Hospital" means a hospital designated and certified as such under the Medicare Rural Hospital Flexibility Program.

E. SERVICES INCLUDED IN THE PROSPECTIVE PAYMENT RATE

The prospective payment rate shall include all services provided in an acute inpatient setting except:

1. Professional component, including physician services or any other professional fees excluded under Part A Medicare;
2. Ambulance; and
3. Durable medical equipment (except for implanted devices) that the patient takes home after he or she is discharged.

II. PREPARATION OF DATA FOR PROSPECTIVE PAYMENT RATE CALCULATION

A. SOURCE

1. The calculation of prospective payment rates shall be based on facility-specific claims and cost data, as follows:
 - a. Cost data shall be abstracted at the time the rate calculation begins from finally-settled uniform cost reports submitted to the Department by each Provider in accordance with federal Medicaid requirements.
 - b. The cost report used for each facility shall be the facility's report which ended during the state fiscal year selected as the Base Year.
 - c. Supplemental costs reporting forms submitted by providers shall be used as necessary. Claims data shall be derived from claims

TN No. 00-008

Supersedes

TN No. 94-006

Approval Date MAR - 8 2001 Effective Date 1/01/01